

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 010680	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/14/2016
NAME OF PROVIDER OR SUPPLIER KEEPSAKE VILLAGE OF COLUMBUS		STREET ADDRESS, CITY, STATE, ZIP CODE 2564 FOXPOINTE DR COLUMBUS, IN 47201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of Complaint IN00200087.</p> <p>Complaint IN00200087 - Substantiated. No deficiencies related to the allegations were cited.</p> <p>Survey Date: June 14, 2016</p> <p>Facility Number: 010680 Provider Number: 010680 AIM Number: N/A</p> <p>Census Bed Type: Residential: 37</p> <p>Sample: 3</p> <p>Keepsake Village of Columbus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00200087.</p> <p>QR was completed by 99993 on 06/16/16.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE